



STATE OF CONNECTICUT
 DEPARTMENT OF CONSUMER PROTECTION
 DRUG CONTROL DIVISION
 COMMISSION OF PHARMACY
 Telephone: (860) 713-6065

APPLICATION FOR A TEMPORARY PERMIT TO PRACTICE PHARMACY

INSTRUCTIONS:

All spaces must be completed - please print or type. This application **must be accompanied by a check or money order in the amount of \$100.00**, made payable to: "Treasurer, State of Connecticut". **This permit shall expire at the time the person is licensed as a pharmacist but no later than six months from the date of issue. It is not transferrable, prorated or renewable.**

→ Return your completed application and fee to:

Department of Consumer Protection, License Services Division, 165 Capitol Avenue, Hartford, CT 06106

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|---|--------------------------------------|
| Name of Applicant | Social Security No.: |
| Home Address (No. & Street, City, State, Zip Code) | Telephone (Include area code) |
| Current State of Licensure and License Number | |
| Name and Address of Pharmacy Where Employed in Connecticut | |

1.) Have you submitted your completed official application for reciprocity to the State of Connecticut? Yes No

If no, please explain: _____

2.) Is your license currently in good standing in your present state(s) of licensure? Yes No

If no, please explain: _____

3.) Are there any disciplinary actions pending against your current pharmacist license(s)? Yes No

If yes, please explain: _____

Has the applicant ever been convicted of a felony crime YES [] NO [] If yes, please attach information concerning the dates(s) of conviction(s), the court(s) where the cases were decided and a description of the circumstances relating to each conviction(s).

I solemnly swear that the information contained herein is true and correct to the best of my knowledge, and I am aware that my temporary permit to practice pharmacy may be suspended or revoked if I violate any pharmacy laws, rules or regulations and hereby affix my signature as acknowledgment and agreement of such terms.

 Signature of Applicant

 Date